Vibrant General Practice for Derbyshire

A vision for the future 2019-2029

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January 2019

Foreword

General Practice in Derbyshire is performing well but is under increasing pressure. With 15,000 consultations (1) every day and a 15% increase in activity over the last 5 years (2) we are witnessing an impending crisis. Changes to our CCGs and the introduction of the STP has led to acknowledgement that something must change. There is an opportunity for General Practice to take control of its destiny; for us to write our own path.

We need to agree and articulate our future so that CCGs, councils and other providers can understand where we want to go and make decisions that support and fit with our direction. This can not be the articulation of one individual: it must be the collective voice of General Practice in Derbyshire. We will own this and it will become ours.

GENERAL PRACTICE IN DERBYSHIRE

The contribution of General Practice to the broader system of health and social care in Derbyshire should not be underestimated; a 1% shift in workload from General Practice would lead to a 15% increase in A&E activity; every additional GP per 10,000 patients is associated with a 6% decrease in mortality (3); 4.7 lives are saved per year by every GP in preventative medicine (4).

Our core ideology has been consistently articulated by the GP Alliance (Appendix A):

To provide high quality, patient-centred, general practice-led care which has freedom to innovate to meet its patients' needs, with organisations and professionals behaving in a mutually supportive manner.

Envisioned Future: the goals for general practice

RIGHT CLINICIAN, RIGHT PLACE, RIGHT TIME

The Goal:

All patients will have access to a general practice-led multidisciplinary team of community care professionals by 2024. As a consequence, no patient will be seen outside their community for their health and social care needs (with defined exceptions), embracing the concept of 'right clinician, right place, right time'.

The Vision:

Patients will understand that their general practice-led community care comprises of a multidisciplinary team of clinical and non-clinical staff to meet their health and social care needs. The patient will thus be supported and empowered by this group of community experts. By ensuring the patient sees the right clinician in the right place, patient time will not be wasted.

GP Partners will be involved at the outset for all decision-making related to primary care provision in Derbyshire, enabling pragmatic, flexible, forward thinking and creative solutions to problem solving. The result of this fundamental shift in resourcing and structure is that general practice-led community care will be the first contact for patients, and thus the first to be funded for all health care contacts bar a few defined exceptions: the concept of '*commission general practice first*' will result.

INVESTMENT IN PATIENTS

The Goal:

In Derbyshire, the share of NHS resources spent on primary care should almost double (from 9% to 15%) within 10 years. This will be part of a broader increase in NHS spending on community-based care to 50% (from approx. 30%) within the same time period.

The Vision:

By moving investment into general practice and wider community-based care, we will see transformation of the way in which the health service functions, with a drive to prevention of disease, rather than purely a reactionary service. This will result in

investment for self-care and social prescribing and truly patient-centred care.

With evidence emphasising the cost-effectiveness of general practice, this transition will result in a reduction in overall health care costs whilst maintaining high quality, well-run services. Reinvestment of savings back into primary care will become an expectation and the standard (Appendix B)

GENERAL PRACTICE WELLBEING

The Goal:

By 2024, no member of the general practice team will leave the profession as a consequence of unsustainable workload and unreasonable working demands.

The Vision:

Current unlimited workload is driving our retention crisis. By using evidence-based approaches including internationally accepted safe workload limits general practice will have time to care for its workforce and patients.

Clinicians will have the confidence in determining appropriate consultation lengths for patients with the core principle that 15minutes is the standard for face-to- face appointments. This will enhance clinician and patient satisfaction.

Practices will be supported to prioritise the wellbeing of the workforce team: with dedicated time for training, supporting, mentoring and nurturing members of the entire team. By caring for, and valuing, the wider general practice team we will promote enriched and meaningful work: retention and ultimately recruitment will be improved.

Appropriate investment, combined with the sharing of local and national impactful modifications to the working day, will support this transition whilst ensuring timely access to the right professional is preserved (1).

THE IMPACT

The net result of this 'Envisioned Future' follows the Institute for Health Improvements 'Triple Aim' namely:

- **Improving patient experience of care (including quality and satisfaction);**
- **Improving the health of populations; and**
- **Improving the value of the money spent on health care.**

The Building Blocks for High Performing General Practice in Derbyshire.

Achieving change, in Derbyshire General Practice, based on the above vision will require a fundamental change and practices will need a roadmap to navigate this.
Based on the article 'The 10 Building Blocks of High-Performing Primary Care' (5), we outline the fundamental building blocks required for success of the above vision.

Enabled leadership, data-driven improvement, and registered populations are seen as the foundations for high performing general practice from which the other tenants can be built.

Enabled leadership

Leaders at all levels of general practice in Derbyshire will be supported and developed. This will include the time, technology and training to achieve this. Leaders and emerging leaders will have the opportunity to learn from and visit other examples of best practice, inside and outside of the NHS. They will feel confident that they are setting the strategic direction for general practice in Derbyshire and will set goals and objectives compelling to patients and staff alike.

Evidence-based improvement

Information will be used to improve the quality of care provided, to support operational challenges around access and continuity and to monitor the experiences of patients. Data will be driven down to individual care teams and will be dealt with transparency to support quality improvement.

Registered populations

Every citizen of Derbyshire will have access to a registered general practice which will be the basis for the therapeutic relationship, supporting continuity and the patient-team partnership. It will need to allow general practice-led clinical teams to ensure a reasonable balance between demand and capacity.

Team-Based Care

General practice recognises the value of a varied clinical and support team to provide acute, chronic and preventative care. Clinical and non-clinical staff will be supported to expand and diversify to 'share the care' and deliver team-based continuity. These general practice-led teams will be locally determined with informal networks being established with specialist services to support the specific health needs of an individual in the community.

Person-Centred Care

Patients will be the focus of their care. They will be engaged in shared decisions and their time will be valued. Clinical teams will be supported in health coaching to promote person-centred care. Self-care will be supported across all contacts with health or social care.

Population Management

The care needs of the registered population will be locally determined and supported by the system; with stratification to match those needs. Those with complex care needs will be identified and supported by an enhanced multi-disciplinary team approach which will meet their psychosocial and physical requirements. Those with chronic health problems will be offered evidence-based approaches such as health coaching; this may be provided by empowered non-clinicians. Proactive identification of those at risk of

disease will be supported by non-clinical staff thus it will be the norm for patients visiting their practice to have other care gaps identified and addressed.

Continuity and Access

Continuity of care is associated with improved preventative care, greater patient and clinician experience and lower costs. Trends of continuity will improve: this will require front desk staff, across all areas of health and social care, to support and encourage patients to see their registered team. Access is closely linked to patient satisfaction and will be improved through team-based care. Where possible Patients will have the choice of whether to prioritise access or continuity.

Coordinated and Comprehensive

The vast majority of a patient's care will be provided in the community by their general practice-led team. Patients leaving their community to receive care should be the exception. Coordination of care will remain a central tenant of General Practice particularly when care becomes increasingly complex.

Long Term Planning

Health and wellbeing are not a time limited feature of and individual's life. Intervals of 5-10years are appropriate timescales to consider. It certainly doesn't follow a financial year. Therefore, interventions to support and improve health and wellbeing by General Practice will be considered over longer time periods. This will support more joined up thinking.

By having system-wide acceptance of and investment in these necessary building blocks, we can turn the vision for Derbyshire general practice into a reality that delivers for patients, the general practice team and the Derbyshire health care system

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3. **Starfield, B, Shi, L and Macinko, J.** Contribution of primary care to health systems and health. *Milbank Quarterly.* 2005.

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Appendix A

GP Alliance – Derbyshire Jan 2019 update

Who are we?

We are a group of Derbyshire based GP leaders, who are representing, advocating for and developing General Practice in Derbyshire.

We are the business owners providing the vast majority of General Practice, primary care and community based care.

We are a strategic alliance which encompasses primary care networks, federations, super-partnerships and GP practices across the totality of Derbyshire.

We influence and develop the system of health and social care in Derbyshire by making autonomous decisions about local General Practice.

The future

Extension of the membership to the wider primary care team across Derbyshire

Formation of a separate and defined leadership group from this extended membership with funding and support from the broader system.

Current Challenges

Interaction with other stakeholders.

Recognition by the system of health and social care of the GP Alliance.

Appointment of the GP Alliance leadership team.

Current membership

Andrew Kitchen, Andrew Maronge, Anne Tompkinson, Anne-Marie Spooner, Avi Bhatia, Chris Harvey, Debbie Austin, Ed Oakley, Emma Pizzey, Helen Hill, Jo Southcott, Jolene Briggs, Justin Walker, Justine Reid, Mahya Johnson, Mark Rooney, Paddy Kinsella, Pauline Love, Penny Blackwell, Peter Williams, PJ Flann, Praveen Alla, Richard Butler, Riten Ruparelia, Robin Thorne, Ruth Cooper, Sam Taylor, Simon Theakston, Susie Bayley, Upendhra Bhatia, Vikas Gupta, Duncan Gooch.

Appendix B

JUCD stated aims

The original STP plan stated a planned shift from 30% to 39% of all care delivered through Place (page 7) between 2016 and 2021, according to the plan £247m more care would be delivered through Place as a result of using our workforce differently, a reduction in care in specialist settings, 10% reduction in infrastructure costs (management and back office) through greater collaboration between NHS Trusts (mergers), greater collaboration between commissioners and reduction in estates costs.

The above was predicated on investment, which never materialised, but was expected to result in a reduction in bed based care of 535 beds. Since 2016, over 100 beds have closed (ie Better Care Closer To Home, CRH) and staff have moved out of hospital settings to deliver community based services ie Dementia rapid Response teams as one example). I think the system recognises that 535 is not credible hence us revisiting this assumption.

Current spend (2017-2018)

	£'000s
Acute Services	777,334
Mental Health Services	165,737
Community Health Services	132,353
Continuing Care Services (CHC)	92,872
Prescribing	145,259
Enhanced services	19,069
Primary Care Co-Comissioning	137,592
Other Primary Care	20,404
Other Programme Services	81,453
Running Cost	20,079
	1,592,152

Financial case for increasing funding (Dr U Bhatia -GP Alliance)

With an increasingly smaller proportion of the budget for primary care provision, there has also been a general trend towards increased healthcare costs in the NHS as a whole. L'Esperance et al (2017) demonstrated that increase in notional investment towards core General Practice funding, modelled savings in secondary care, and therefore across the system. This clearly highlighted the ability of General practice to save money in the system, and why the NHS is so resilient. However, this is being put at risk through the funding squeezes that primary care has faced over the years.

One of the aims of the health system is also to provide more equitable funding and health provision with access. Barbara Starfield as conducted many studies into the role and impact of primary care on health systems. Her work with Macinko and Shi (Macinko et al, 2003; Starfield et al 2005) when looking at a number of health systems across OECD countries concluded that a strong primary care was associated with improved population health. Starfield et al (2005) also suggest evidence that primary care (in contrast to specialized care) is associated with more equitable distribution of health in populations, which can be shown in cross national and within national studies. Therefore this, together with L'Esperance's work (2017), argues that a strong and well funded primary care will reduce costs and improve health outcomes. These sentiments are also echoed by Rao and Pilot (2014).

With regards to understanding how much investment could be considered reasonable at this time, recent evidence from the United states demonstrates that for every 1$ invested in primary care, 13$ is saved in down stream costs (Stream, 2018). Further to this Stream also cites that according to the American Academy of Family Physicians, if the United Sates spent closer to 12% of its health dollars on primary care, and this would reduce per patient costs and deliver a reduction in overall healthcare expenditure. Focusing on value and having patients at the centre of care, with coordination and collaborative working across other health professionals is thought to be the principle way to deliver the savings and implementation. But this requires adequate funding and system wide change and recognition for investment into primary care.

Therefore the GP Alliance would propose a gradual shift towards 15% over a 10 year period in Derbyshire, which is primarily focused on GP practices and associated alliances.

Current spending across Derbyshire is £1,592,152, and 9% currently goes to primary care co commissioning.

The GP Alliance propose an initial 2% increase in the primary care co-commissioning budget, and an annual 0.5% increase therefore after till reaching 15%. By extrapolation, this is a £31 million increase towards primary care in the first year, but can result in

£300million pounds of recurrent savings across the system over the subsequent time after year 2. This would allow the funding to be invested in frontline services and staff, improving morale and develop access mechanisms to sustain the workforce and manage demand. The flexibility and speed at which these changes can occur is in line with one of the strengths of General Practice and primary care.
The further increases in budget would allow improved access and more specialized services to be delivered in an integrated fashion with General practice, further consolidating savings and simultaneously improving access, and health outcomes.

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